

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

CERTIFICATE OF DEATH

12870

Reg. Dist. No. 262

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge		b. COUNTY St. Maryland			
c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First: David Middle: Chester Last: Dean		4. DATE OF DEATH Month: December Day: 19 Year: 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1926		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Labor		10b. KIND OF BUSINESS OR INDUSTRY Bricklayer			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Richard Dean		14. MOTHER'S MAIDEN NAME Myrtle Mae Copsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Chester Dean Ridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month: 19 Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE William H. Patrick M.D.				ADDRESS (Street, city or town, state) California, Md. DATE SIGNED 12-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/56		22c. NAME OF CEMETERY OR CREMATORIAL Joy Chapel	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12/20/56	
				24b. REGISTRAR'S SIGNATURE Alan S. Hansen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be ret'd by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT DOCUMENTS LIBRARY
SERIALS DEPT.

BUREAU V. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12883

CERTIFICATE OF DEATH

12871

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaptico	
3. NAME OF DECEASED (Type or print) Lucy		d. STREET ADDRESS	
4. DATE OF DEATH December		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1886	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-8342	
17. INFORMANT Miss Mary R. Fowler		Address Chaptico, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 164X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Dec 9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 9</u> , 19 <u>56</u> and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Dr. J. Roy Guyther</u>		ADDRESS (Street, city or town, state) <u>MacNamee's</u> , Md 12/9/56 DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. J. Roy Guyther M.D.		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 12/12/56	
		24b. REGISTRAR'S SIGNATURE Alen L. Hauser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE ARCHIVES - MURKIN 18

CHIEF CIVILIAN OFFICER

BUREAU V. 2

DEC 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12872

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
12884 St. Marys MARYLAND		b. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Rt. 235 Lexington Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print)		First	Middle
Adolph		---	Halvorsen
4. DATE OF DEATH	Month	Day	Year
12/ 15 / 1956			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/1889
male	white	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY porter cafeteria	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Halvorsen		14. MOTHER'S MAIDEN NAME Ellen Hansen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes 1918-1919		16. SOCIAL SECURITY NO. 33-07-6426	
17. INFORMANT Mrs. Elizabeth Martinsen		Address 431-11 St. Brookl and, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERNAL BETWEEN ONSET AND DEATH Fractured cervical vertebra Innerv	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 819X		DUE TO (b)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile collision	
20c. TIME OF INJURY Month, Day, Year Hour 8 a.m. Dec 15 1956 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Lexington Park St. Marys Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> J. Roy Guyther			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/56	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 12/20/56	
24b. REGISTRAR'S SIGNATURE Almond. Hansen/12			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

STATE OF HAWAII
DEPARTMENT OF DEFENSE

25-1700

500 - 1000

BUREAU V. S

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

CERTIFICATE OF DEATH

Reg. Dist. No. 12873

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN lb 48 minutes					
d. NAME OF HOSPITAL (If not in hospital, give street address) Station Hospital, USNAS, Patuxent River, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River, X					
3. NAME OF DECEASED. (Type or print)		First	Middle				
4. DATE OF DEATH		Month	Day				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-56	9. AGE (In years lost birthday) yrs. 48	10. IF UNDER 1 YEAR Months Days Hours Min 48	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hutton		14. MOTHER'S MAIDEN NAME Anne Wilhelmina Hauer		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT None J. Hutton, USNAS, Patuxent River, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 774X		CARDIAC-RESPIRATORY FAILURE		INTERVAL BETWEEN ONSET AND DEATH 48 minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO IMMURITY		48 minutes			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 17 Dec 1956, to 17 Dec 1956, that I last saw the deceased alive on 17 Dec 1956, and that death occurred at 9:31 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles E. Look</i> M.D. ADDRESS (Street, city or town, state) DATE SIGNED Station Hospital, USNAS, 12-18-56							
PHYSICIAN'S NAME (Type) C. E. LOOK, LT MC USNR		Patuxent River, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-56		22c. NAME OF CEMETERY OR CREMATORIAL Holy Face Cem.		22d. LOCATION (City, town, or county) Lexington Park, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24e. REC'D BY REGISTRAR DATE 12-21-56		24b. REGISTRAR'S SIGNATURE <i>P. J. Beary, M.D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9561 98 030

REGELYÉD

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, reburial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18, 20&21 Film G205 12-26-56 505

14074

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 282

12886

1. PLACE OF DEATH
a. COUNTY

St Mary's

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY

St Mary's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Leonardtown

c. LENGTH OF STAY IN 1b

20 Min.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

St. Mary's Hospital

3. NAME OF
DECEASED
(Type or print)

First Charles

Middle

Last

4. DATE
OF
DEATH

Month December
Day 6, 1956

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
at birthday)

10. IF UNDER 1 YEAR
Months 1
Days 28

11. IF UNDER 24 HRS.
Hours 0
Min. 0

Male

White

WIDOWED

DIVORCED

Oct. 8/1874

87 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Patent Office

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Government

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Henry Jarboe

14. MOTHER'S MAIDEN NAME

Mary Rebecca Adams

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Miss Louise Jarboe Leonardtown, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Nicotine Poisoning

971.8

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Drank Insecticide

20c. TIME OF INJURY
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)
Leonardtown
Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Paul F. Guerin, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/6/56

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)
Md.

Burial

12/8/56

St Paul's

Leonardtown,

(State)
Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Clarke Mattingley Leonardtown, Md.

24a. REC'D BY REGISTRAR

DATE 12/7/56

24b. REGISTRAR'S SIGNATURE

Glen A. Nausler

RECEIVED
BUREAU V. S.

DEC 10 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 455 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

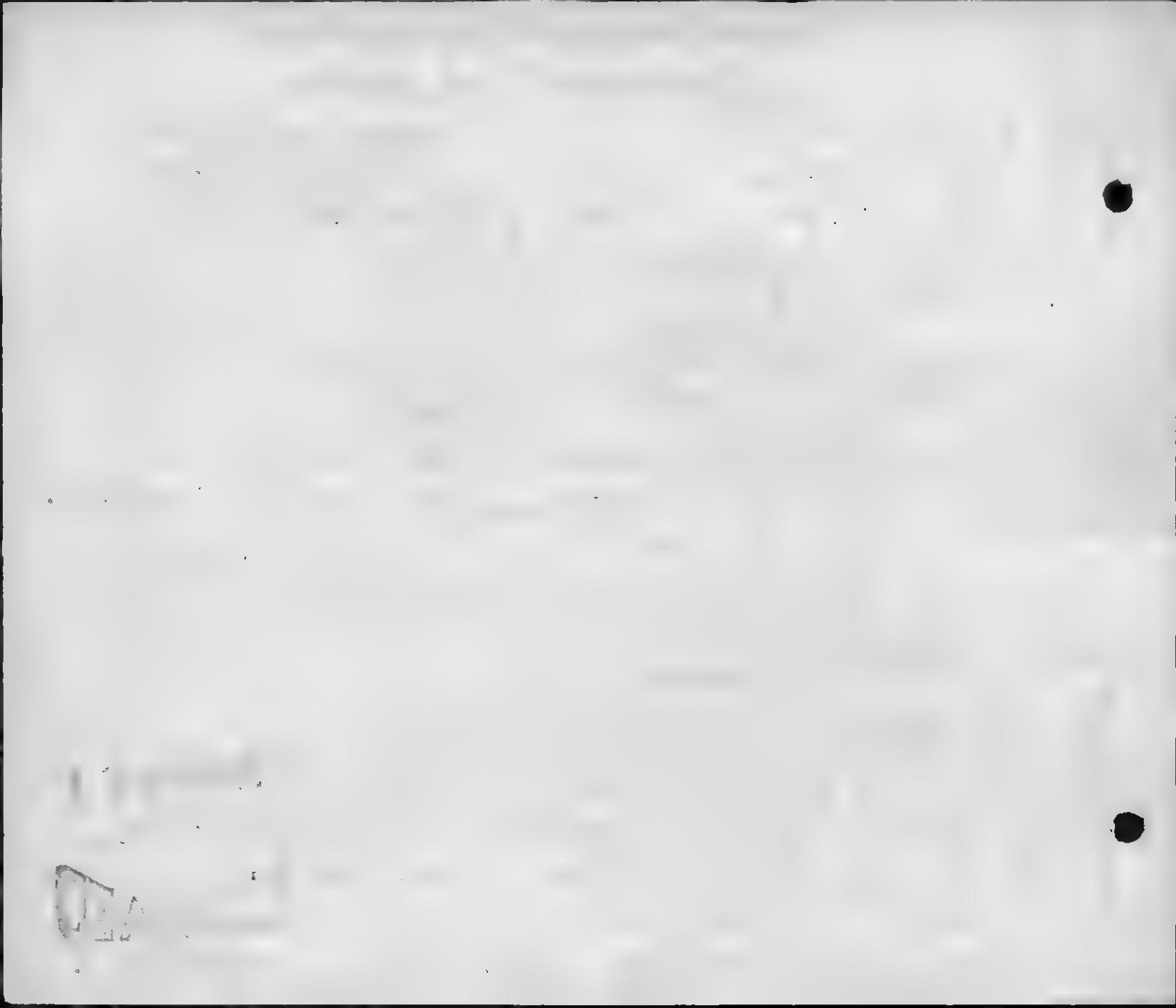
12875

CERTIFICATE OF DEATH

12887

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY	St. Marys	MARYLAND	STATE	Maryland	COUNTY	St. Marys	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)				
TOWN	California	life	TOWN	California			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	rural	STREET ADDRESS	(If rural give location)				
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Samuel ----- Kane				12/28/1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
male	colored	married	5/15/1872	84 yrs.	Months	Days	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
farming		farm tenant	Maryland		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Hillary Kane				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Isabelle Barnes- California, Md.			
18. MEDICAL CERTIFICATION							
<p>IMMEDIATE CAUSE (A) <i>General sclerosis and hemorrhage</i></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized arterio sclerosis</i></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>6 years</i></p> <p>STATING UNDERLYING CAUSE LAST.</p>							
INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <i>May 1950</i> to <i>Dec 1956</i>, that I last saw the deceased alive on <i>Dec 26, 1956</i>, and that death occurred <i>11:30PM</i>, from the causes and on the date stated above.							
SIGNATURE <i>P.J. Bean M.D.</i>							
ADDRESS (Street, city, town, state) <i>Great Mills, Md.</i> DATE SIGN <i>12/30/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		
Burial		12/31/56	Holy Face Cemetery		Great Mills, Md.		
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>John M. Robinson</i> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>P.B. Robinson - Leonardtown, Md.</i>							
DATE <i>12/30/56</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

128762

Reg. Dist. No.

12858

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First William	Middle Joseph	Last Lawrence	4. DATE OF DEATH Month Dec. 6, 1956	Day	Year
--	----------------------	----------------------	----------------------	---	-----	------

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 18, 1919	9. AGE (In years last birthday) 37 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
----------------	---------------------------	---	---	---	-------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver	10b. KIND OF BUSINESS OR INDUSTRY milk dairy	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? usa
--	---	---	---

13. FATHER'S NAME Arthur B. Lawrence Sr.	14. MOTHER'S MAIDEN NAME Florence Morris
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW 2	17. INFORMANT Corinne L. Lawrence- Abell, Md.	Address
--	---	--	---------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 1 714.0	Electric shock	INTERVAL BETWEEN ONSET AND DEATH immed
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Contacted high voltage electric line	
--	--	--

20c. TIME OF INJURY Hour 4:56 p.m.	Month, Day, Year DEC 6 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Abell St. Marys Co. Md	(County)	(State)
--	--------------------------------	--	--	---	----------	---------

21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
---	--	--	--	--	--	--

ACTUAL SIGNATURE EXAMINER'S NAME (Type) J. Roy Guyther	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED
--	--	-------------

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/10/56	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart	22d. LOCATION (City, town, or county) Bushwood, Md.
---	-------------------------------	--	--

23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 12/11/56	24b. REGISTRAR'S SIGNATURE Glenda L. Hauser
--	---------	--	--

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SCREAU V. 2

20 100 200

SCREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889

CERTIFICATE OF DEATH

Reg. Dist. No. 282

12877

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 2Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) Baby	First Middle Girl	Last Mattingly	4. DATE OF DEATH December 21, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Jennings Mattingly		14. MOTHER'S MAIDEN NAME Hilda Marie Watts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Intra cranial hemorrhage Prematurity - 7 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Absence of external genitalia, imperforate anus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of line 18.)	
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above ADDRESS (Street, city or town, state)		DATE SIGNED Mechanicsville 12/22/56	
ACTUAL SIGNATURE J. Roy Guyther		M.D.	
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.		Mechanicsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius		22d. LOCATION (City, town, or county) Leonardtown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 12/27/56	
24b. REGISTRAR'S SIGNATURE Alan L. Harvey			

BULEAU V. S

DEC 10 1966

LIBRARY
UNIVERSITY OF TORONTO LIBRARIES
100
100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12878

12899

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park		c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Archie	Last Moore	4. DATE OF DEATH December 26, 1956	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1899	9. AGE (in years, last birthday) 57 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Hill		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 426-14-1382		17. INFORMANT Ella Moore Lexington Park, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 30 min.		
(b)		DUE TO myocarditis				1 year		
(c)		DUE TO Hypertensive Cardio Vascular Disease				10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from Sept 1, 1956 to Dec 26, 1956 that I last saw the deceased alive on Dec 15, 1956, and that death occurred at 5:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE Dr. W.H. Patrick				M.D. Lexington Park Md. 12-26-56				
PHYSICIAN'S NAME (Type)		William H. Patrick M.D.		California, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/56		22c. NAME OF CEMETERY OR CREMATORIAL Ebeneza		22d. LOCATION (City, town, or county) Towson Mills, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Nattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12/22/56		24b. REGISTRAR'S SIGNATURE Alan A. Hooper		

SHEDAU V. S.

10 1996

REGGIE VILLE

12878

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY		12891 St. Marys		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Abell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
a. STATE		MARYLAND		b. STATE		Maryland		b. COUNTY		St. Marys	
c. STREET ADDRESS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First James		Middle LeRoy		Last Morris		4. DATE OF DEATH		Month Dec. 6, 1956	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years at birth)		10. IF UNDER 1 YEAR Months Days Hours Min.	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 11, 1917		39 yrs.		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Watherman				Sea Food				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
William S. Morris				Ethel Crismond				usa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT			
yes				WW 2 579-61-3664				Charles S. Morris- Abell, Md.			
Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electric shock</u> INTERVAL BETWEEN ONSET AND DEATH <u>unmeasured</u>											
914.0 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO											
DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour <u>4:55</u> p.m. Month, Day, Year <u>Dec 6 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Abell St. Marys Co. Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>J. Roy Guyther</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12/7/56</u>			
EXAMINER'S NAME (Type)		J. Roy Guyther		actg.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)			
Burial		12/10/56		Sacred Heart		Bushwood, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
P.B. Robinson - Lepnardtown, Md.								DATE <u>12/10/56</u>		Signature <u>Glenn D. Lauer</u>	

BUENO M. A.

DEC 12 1966

MEMORANDUM

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completely filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 208 12-28-56 ams

CERTIFICATE OF DEATH

128802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maria Turner		First	Middle	Last	4. DATE OF DEATH December	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1859	9. AGE (in years from birth) 97 yrs.	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS. Days 3	12. Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wilson Turner				14. MOTHER'S MAIDEN NAME Martha Turner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fall setting out of bed						
20c. TIME OF INJURY Hour: 6 p.m. Min: 00 p.m. Nov 24 1956		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Mechanicsville	(County) St. Mary's	(State) Md.
21. I certify that I attended the deceased from <u>Jan 18</u> , 1956, to <u>Dec 10</u> , 1956, that I last saw the deceased alive on <u>Dec 10</u> , 1956, and that death occurred at <u>2:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md.								
DATE SIGNED 12/14/56								
ACTUAL SIGNATURE <i>J. Roy Guyther</i>		M.D.						
PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.		Mechanicsville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORIAL All Faith		22d. LOCATION (City, town, or county) New Market, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.								
ADDRESS					24a. REC'D BY REGISTRAR DATE 12/14/56			
					24b. REGISTRAR'S SIGNATURE <i>W. Clarke Mattingley</i>			

BUREAU V. 4

EC 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

Reg. Dist. No. 382

12893

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurry Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) Baby			First Baby	Middle Girl	Last Somerville
4. DATE OF DEATH December 3, 1956			Month December	Day 3	Year 1956
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1956	9. AGE (in years last birthday) 1 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Joseph Somerville			14. MOTHER'S MAIDEN NAME Mary Josephine Young		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
			William Joseph Somerville	Hurry, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 13 hrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. p. p. m.	Month 12	Day 3	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12/2	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on 12/3/56 , and that death occurred on 12/3/56 , at 8:15 M., from the causes and on the date stated above.			ADDRESS (Street, city or town, state) M.D. Somerville, Md. DATE SIGNED 12/3/56		
ACTUAL SIGNATURE <i>Ray L. Guyles</i>		PHYSICIAN'S NAME (Type) St. Aloysius		22d. LOCATION (City, town, or county) Leonardtown, Maryland (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/56		22c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley			ADDRESS Leonardtown, Md.		
24a. REC'D BY REGISTRAR 12/7/1956			24b. REGISTRAR'S SIGNATURE Alma J. Hauser		

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be mailed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/35

BUFEAU V. S.

DEC

BUFEAU

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and immediately filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12882

CERTIFICATE OF DEATH

12894

Reg. Dist. No. 281

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	St. Marys Leonardtown	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lexington Park, STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Marys Hospital		Rural	
3. NAME OF (First) Margaret (Type or Print)		(Middle) Jane (Last) Stevens	
4. DATE OF DEATH 12/ 29 / 56		(Month) (Day) (Year)	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 5/30/1873
9. AGE last birthday 83 yrs.	10. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Shade	14. MOTHER'S MAIDEN NAME Massie Arndt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes) <input checked="" type="checkbox"/> (No) <input type="checkbox"/> (If Yes, give rank and date of service)	16. SOCIAL SECURITY NO. -----		
17. INFORMANT & ADDRESS Robert A. Stevens-		Lexington Park Md.	
18. MEDICAL CERTIFICATION			
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arthritis deformans</u></p>			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
10 years			
10 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1945, to 1906, that I last saw the deceased alive on Dec. 28, 1956, and that death occurred at 11:15 AM, from the causes and on the date stated above. SIGNATURE <u>P. J. Bean</u> ADDRESS <u>Great Mills, Md.</u> GNE			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/31/56	
24. REC'D BY REGISTRAR DATE 12/30/56		NAME OF CEMETERY OR CREMATORI Ebenezer Cemetery	
REGISTRAR'S SIGNATURE <u>John M. Robinson</u>		LOCATION (City, town, or county) California, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS	

A.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12883

CERTIFICATE OF DEATH

12895

Reg. Dist. No. 282

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY St. Marys	MARYLAND	STATE Maryland	COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	STREET ADDRESS	
TOWN Leonardtown		TOWN Mechanicsville	(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rural			
St. Marys Hospital				
3. NAME OF DECEASED (Type or Print)	(First) Sarah	(Middle) Cecelia	(Last) Tennyson	4. DATE (Month) OF DEATH 12/ 28 / 1956 (Day) (Year)
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, widowed	8. DATE OF BIRTH 8/21/1877	9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Gates		14. MOTHER'S MAIDEN NAME Sarah Burch		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS J. Burch Tennyson- Mechanicsville, Md.
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Cardiac decompensation</i> / mo ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Chronic pulmonary emphysema</i> 5 yrs GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO DISEASE OR CONDITION CAUSING DEATH. (C) <i>cor pulmonale</i> <i>Bronchial asthma</i> 20 yrs <i>Arthritis, rheumatoid</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan. 1948, to Dec. 28, 1956, that I last saw the deceased alive on Dec. 27, 1956, and that death occurred at 9:50 P.M. from the causes and on the date stated above. SIGNATURE <i>J. Roy Guyther</i> ADDRESS (Street, city, town, state) DATE SIGNED M.D. Mechanicsville, Md. 12/28/56				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/31/56	NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	LOCATION (City, town, or county) Washington, D.C.
24. REC'D BY REGISTRAR DATE 1/2/57		REGISTRAR'S SIGNATURE <i>Donald J. Hauser</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P.B. Robinson - Leonardtown, Md.	

RECEIVED
BUREAU V. S.

JAN 3 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12896

CERTIFICATE OF DEATH

12884

Reg. Dist. No. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial-pass permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 12 hrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood				
3. NAME OF DECEASED (Type or print) Melvin		First Leroy	Middle Weeks			
4. DATE OF DEATH December 26	Month Year 1956	5. SEX Male	6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. B. DATE OF BIRTH March 13, 1908	9. AGE (In years lost birthday) 48	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 13		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat repair	10b. KIND OF BUSINESS OR INDUSTRY Ship Yard	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Pirley Weeks		14. MOTHER'S MAIDEN NAME Virginia Combs		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 216-14-2122		17. INFORMANT Mrs Melvin L. Weeks		Address Hollywood, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 24 hrs				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mechanicsville, Md	(County)	(State)
21. I certify that I attended the deceased from Jan 1956 to Dec 26, 1956, that I last saw the deceased alive on Dec 26, 1956, and that death occurred at 7A M, from the causes and on the date stated above. ACTUAL SIGNATURE J. Roy Guyther PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/56	22c. NAME OF CEMETERY OR CREMATORIAL Joy Chapel	22d. LOCATION (City, town, or county) Hollywood, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12/31/56	24b. REGISTRAR'S SIGNATURE alan N. Hammar	

DEPARTMENT OF DEFENSE
CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12885

282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH 12897		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	St. Marys Mechanicsville	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rural	life	COUNTY St. Marys Mechanicsville (If rural give location)
3. NAME OF DECEASED (First) James (Middle) Wilbert (Last)		4. DATE OF DEATH 12 / 22 / 1956 (Month) (Day) (Year)	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 6 / 13 / 56
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Platter		14. MOTHER'S MAIDEN NAME Gladis M. Winters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT & ADDRESS Gladis M. Winters - Mechanicsville Md.		18. MEDICAL CERTIFICATION	
<p>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>527.2 IMMEDIATE CAUSE (A) Respiratory infection-acute, fulminating, with probable septicemia</p> <p>ANTECEDENT CAUSE(S) DUE TO (B) 2 d.</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATEMENT UNDERLYING CAUSE LAST. DUE TO (C) -----</p> <p>2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<p>22. I hereby certify that I attended the deceased from 12/22/56 to 12/22/56, that I last saw the deceased alive on 12/22/56, and that death occurred at 10A.M. from the causes and on the date stated above.</p> <p>SIGNATURE <i>J. Roy Guyther</i> M.D. ADDRESS (Street, city, town, state) DATE SIGNED</p> <p>23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 12/24/56 NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery LOCATION (City, town, or county) Morganza, Md. (State)</p> <p>24. REC'D BY REGISTRAR DATE 12/22/56 REGISTRAR'S SIGNATURE Alan N. Hauser ADDRESS</p> <p>25. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.</p>			

U. S. DEPARTMENT OF JUSTICE, ATTORNEY GENERAL'S OFFICE

CHIEF COUNSEL TO THE DEPARTMENT OF JUSTICE

Dear Sir:

BUREAU V. S.

DEC 25 1956

RECEIVED